as fiduciaries, meaning they must exercise sound management consistent with rules established by a plan sponsor. They must provide written notice to beneficiaries whose claims have been denied, setting forth the reasons. They must disclose some information about the plan to participants of beneficiaries. They cannot discriminate against beneficiaries. They have to allow certain employees, usually those who have been terminated, to purchase COBRA coverage. They have to provide coverage to adopted children in the same manner they cover natural children, and they have to comply with the 1996 HIPAA law in regards to portability.

That sounds all right, but consider what ERISA does not require. Among its many requirement shortcomings, ERISA does not impose any quality assurance standards or other standards for utilization review. ERISA does not allow consumers to recover compensatory or punitive damages if a court finds against the health plan in a claims dispute. ERISA does not prevent health plans from changing, reducing or terminating benefits; and with few exceptions ERISA does not regulate the design or content such as covered services or cost sharing of a plan. Remember from the Jones case how important that can be. And ERISA does not specify any requirements for maintaining plan solvency.

I confess, I cannot understand why some Members would want to place more employees in health plans regulated by ERISA. If anything, we should be moving in the opposite direction and returning regulatory authority to State insurance commissioners.

The patient protection legislation is intended to fix some very real problems in ERISA. I will not consider adding to the number of people under its regulatory umbrella until I see meaningful patient protections for them signed into law.

I am certainly not alone in my concerns about association health plans. When they were proposed as part of the Republican patient protection bill last year, they drew significant opposition from Blue Cross/Blue Shield plans and the National Association of Insurance Commissioners.

Blue Cross, the insurer of last resort for many States, fears that association health plans will undermine State programs to keep insurance affordable. Joined by the Health Insurance Association of America, they wrote, ''Association health plans would undermine the most volatile segments of the insurance market, the individual and small group markets. The combinations of these with healthmarts could lead to massive market segmentation and regulatory confusion.''

A constituent of mine and an insurance industry professional wrote to me to express his concerns about association health plans. He wondered why these plans ''can sell whatever level of benefits they want to provide and can limit coverage for any type of benefit the plan might want to cover.''

Now, some may say that these concerns reflect the self-interest of the industry. Before buying into that argument, consider an editorial by The Washington Post a year ago. In criticizing association health plans, and I would say, by extension, healthmarts, the Post pointed out that, ''if you free the MEWAs, multiple employer welfare associations, you create a further split in the insurance market which likely will end up helping mainly healthy people at the expense of the sick.''

Some may say that The Washington Post is a relentlessly liberal paper and that it cannot be considered an objective source. Then consider what the American Academy of Actuaries had to say about association health plans. In a letter to Congress in June, 1997, they wrote, ''While the intent of the bill is to promote association health plans as a mechanism for improving small employers' access to affordable health care, it may only succeed in doing so for employees with certain favorable risk characteristics. Furthermore, this bill contains features which may actually lead to higher insurance costs.''

The Academy went on to explain how these plans could undermine State insurance regulation. ''The resulting segmentation of the small employer group market into higher and lower cost groups would be exactly the type of segmentation that many State reforms have been designed to avoid. In this way, exempting them from State mandates would defeat the public policy purposes intended by State legislatures.''

The Academy also pointed out that these plans ''weaken the minimum solvency standards for small plans relative to the insured marketplace, which may increase the chance for bankruptcy of a health plan.''

Still not convinced? Well, how about a letter jointly signed by the National Governors Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners. In a letter to Congress, these groups argued that association health plans, and I might add healthmarts, ''substitute critical State oversight with inadequate Federal standards to protect consumers and to prevent health plan fraud and abuse.''

Think these are just the concerns of Washington insiders? Legislators in my own State took time to write and express their concerns about association health plans. A letter signed by six members of the Iowa House of Representatives urged rejection of association health plans. They wrote, ''Under the guise of allowing employers to join large purchasing groups to lower health care costs, these proposals would result in large premium increases for small employers and individuals by unraveling State insurance reforms and fragmenting the market.''

Mr. Speaker, attempting to attach association health plan legislation or healthmart legislation to patient protection legislation poses two very real dangers. First, association health plans undermine the individual insurance market and can leave consumers without meaningful protections from HMO abuses; and, second, I am very concerned that opposition to healthmarts and association health plans, much like that I have already cited today, will bog down patient protection legislation, leading it to suffer the same death that it did last year.

Mr. Speaker, on behalf of patients like Jimmy Adams, who lost his hands and feet because an HMO would not let his parents take him to the nearest emergency room, I will fight efforts to derail managed care reform by adding these sorts of extraneous provisions; and I pledge to do whatever it takes to ensure that opponents of reform are not allowed to mingle these issues in order to prevent passage of meaningful patient protections.

Mr. Speaker, I look forward to working with all my colleagues to see that passage of real HMO reform is an accomplishment of the 106th Congress, something we all, on both sides of the aisle, can be proud of.

RECESS

The SPEAKER pro tempore (Mr. PEASE). Pursuant to clause 12 of rule I, the Chair declares the House in recess until approximately 6 p.m.

Accordingly (at 4 o'clock and 15 minutes p.m.), the House stood in recess until approximately 6 p.m.

□ 1800

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. BRADY of Texas) at 6 p.m.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 775, YEAR 2000 READINESS AND RESPONSIBILITY ACT

Mr. DREIER, from the Committee on Rules, submitted a privileged report (Rept. No. 106–134) on the resolution (H. Res. 166) providing for the consideration of the bill (H.R. 775) to establish certain procedures for civil actions brought for damages relating to the failure of any device or system to process or otherwise deal with the transition from the year 1999 to the year 2000, and for other purposes, which was referred to the House Calendar and ordered to be printed.